



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

American Specialty Pharmacy

**Respondent Name**

State Office of Risk Management

**MFDR Tracking Number**

M4-15-3112-01

**Carrier's Austin Representative**

Box Number 45

**MFDR Date Received**

May 22, 2015

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** No position statement submitted

**Amount in Dispute:** \$341.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Upon notification of this dispute the Office performed a review of the medical billing received from American Specialty Pharmacy, which revealed the services are to be denied for 197-Precertification/authorization/notification absent; however our cost containment vendor placed an incorrect CARC code on the explanation of benefits. Out of good faith the Office will have the audit corrected, however will maintain our denial for 197 – as research of the claim did not locate preauthorization for the medications as prescribed. An in-depth review of the dispute packet revealed the charges in dispute are for an opioid medication that is not listed in the Division's Drug Formulary. The Office was unable to locate preauthorization for the medication Lidocaine as billed under NDC # 00603188016 on this claim. Further research found that Lidocaine is a status "N" Medicare in the ODG Treatment in Workers' Compensation (ODG) /Appendix A, ODG Workers' Compensation Drug Formulary."

**Response Submitted by:** State Office of Risk Management

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2014	Lidocaine 5%	\$341.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.540 sets out requirements for use of the closed formulary for claims subject to certified networks.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes;
  - 242 – Services not provided by network/primary care providers

## **Issues**

1. Did the respondent maintain their denial found on the explanation of benefits?
2. What is the applicable rule?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The denial of the services in dispute contained denial code 242 – “Services not provided by network/primary care providers. The respondent states in their position, “Upon notification of this dispute the Office performed a review of the medical billing received from American Specialty Pharmacy, which revealed the services are to be denied for 197- precertification /authorization / notification absent, however our cost containment vendor placed an incorrect CARC code on the explanation of benefits. Out of good faith the Office will have the audit corrected, however will maintain our denial for 197 – as research of the claim did not locate preauthorization for the medications as prescribed.” The denial for non network provider was not maintained and therefore will not be addressed in this review.
2. Review of the TX COMP claim profile at <https://txcomp.tdi.state.tx>, shows an active Certified network. Therefore, the applicable rule is 28 Texas Administrative Code §134.540 (b) which states in pertinent part, “Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for:
  - (1) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
  - (2) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and
  - (3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

The services in dispute are for Lidocaine 5%. Review of the Appendix A, ODG Workers’ Compensation Drug Formulary lists – Topical analgesics - “Lidocaine” – with a status of “N”. As stated above prior authorization was required for this medication but was not obtained. Requirements of Rule 134.540 were not met.

3. No additional payment can be recommended as the submitted documentation was insufficient to support reimbursement guidelines of the Division were met.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

_____	_____	August 17, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**